



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS ORTHOPEDIC HOSPITAL
3701 KIRBY DRIVE STE 1288
HOUSTON TX 77098-3926

Carrier's Austin Representative Box
#47

Respondent Name

AMERICAN CASUALTY CO OF READING PA

MFDR Date Received

DECEMBER 11, 2006

MFDR Tracking Number

M4-09-0058-01 (formerly M4-07-2473-01)

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated December 8, 2006: "There was no on-site audit performed by the insurance carrier. The appropriateness of the medical care was not questioned, nor were any items or services excluded from the claim in question as being 'personal items', 'not-related' or otherwise excludable on any basis authorized by the payment rules of the Division of Workers' Compensation, (hereafter referred to as the 'Division').... Per Rule 134.401 (c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%."

Amount in Dispute: \$46,629.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated January 4, 2007: "We have been retained by American Casualty Company of Reading, PA to represent its interests in the above-referenced medical dispute...Attached is the completed DWC-60 form Initial Request for Medical Dispute Resolution."

Respondent's Supplemental Position Summary Dated February 5, 2007: "The inpatient hospital fee guideline does not apply to outpatient admissions. Subsection (a)(4) of the guideline states, 'Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements'. Therefore, the stop-loss exception to the inpatient hospital fee guideline would not be applicable to determine reimbursement in this case. Rather, outpatient hospital services are reimbursed at fair and reasonable rates pursuant to the statutory standards for reimbursement under the Act. Because the inpatient hospital fee guideline does not apply to outpatient hospital admissions, Provider has not asserted any ground upon which relief can be granted. Therefore, its request for medical dispute resolution must be dismissed...The Carrier reimbursed the Provider \$2,100.78 for facility services associated with the outpatient admission."

Responses Submitted by: Stone, Loughlin & Swanson, LLP

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
December 19, 2005 Through December 20, 2005	Inpatient Hospital Services	\$46,629.88	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- 45 – Charges exceed your contracted legislated fee arrangement.
- 900-021 – ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE.
- W12 – Extent of injury. Not finally adjudicated.
- 880-125 – DENIED PER INSURANCE: NC (NON-COVERED) PROCEDURE OR SERVICE. 100%
- 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change effective 4/1/2007: At least one Remark Code must be provided
- 855-022 – CHARGE DENIED DUE TO LACK OF SUFFICIENT DOCUMENTATION OF SERVICES RENDERED \$0.00
- W1 – Workers Compensation State Fee Schedule Adjustment
- 647-002 – REIMBURSEMENT HAS BEEN CALCULATED BASED ON A PERCENTAGE OF THE CHARGES.
- 900-030 – ABR: THIS BILL WAS REVIEWED THROUGH THE ADVANCE BILL REVIEW PROGRAM
- W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
- 850-243 – ABR: THE RECOMMENDED PAYMENTS ABOVE REFLECT A FAIR, REASONABLE AND CONSISTENT METHODOLOGY OR REIMBURSEMENT PURSUANT TO THE CRITERIA SET FORTH IN SECTION 413.011(D) OF THE TEXAS WORKERS' COMPENSATION ACT. M-NO MAR \$0.00
- 850-243 – ABR: THE RECOMMENDED PAYMENTS ABOVE REFLECT A FAIR, REASONABLE AND CONSISTENT METHODOLOGY OR REIMBURSEMENT PURSUANT TO THE CRITERIA SET FORTH IN SECTION 413.011(D) OF THE TEXAS WORKERS' COMPENSATION ACT. M-NO MAR \$1,100.00

Issues

1. Does an extent of injury issue exist in this dispute?
2. Does the submitted documentation support a contractual agreement issue exist in this dispute?
3. Did the audited charges exceed \$40,000.00?
4. Did the admission in dispute involve unusually extensive services?
5. Did the admission in dispute involve unusually costly services?
6. Is the requestor entitled to additional reimbursement?

Findings

28 Texas Administrative Code §134.401(b)(1)(B) states “Inpatient Services – Health care, as defined by the Texas Labor Code §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital.”

Page 1 of the hospital records under the heading Pre-Op Nursing Diagnosis Screens indicates “Into PRE-OP Holding: 12/19/05 1200.” Page 16 of the hospital records discharge instructions indicates: “12/20/05 1449.”

The Division finds the submitted documentation supports that the length of stay exceeded 23 hours; therefore, the disputed services are inpatient hospital services.

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals’ November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 South Western Reporter Third 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that “to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services.” Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals’ November 13, 2008 opinion, the division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that “Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection...” 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code “W12.”

A review of Division records finds that the compensable injury was the lumbar spine. The disputed treatment was for the lumbar spine.

The respondent states in the position summary that “The Carrier reimbursed the Provider \$2,100.78 for facility services; therefore, the Division finds that an extent of injury issue does not exist in this dispute.

2. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code “45.”

Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

3. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states “...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold.” Furthermore, (A) (v) of that same section states “...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed...” Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$62,173.17. The Division concludes that the total audited charges exceed \$40,000.
4. 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that “This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.” The Third Court of Appeals’ November 13, 2008 opinion states that “to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that

the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services” and further states that “...independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases.” The requestor in its position statement states that “Per Rule 134.401 (c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor (‘SLRF’) of 75%.” This statement does not meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C) because the requestor presumes that the disputed services meet Stop-Loss, thereby presuming that the admission was unusually extensive. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C).

5. 28 Texas Administrative Code §134.401(c)(6) states that “Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.” The Third Court of Appeals’ November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. The requestor’s position statement does not address how this inpatient admission was unusually costly. The requestor does not provide a reasonable comparison between the cost associated with this admission when compared to similar surgical services or admissions, thereby failing to demonstrate that the admission in dispute was unusually costly. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(6).
6. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
 - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that “The applicable Workers’ Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission...” The length of stay was one day. The surgical per diem rate of \$1,118.00 multiplied by the length of stay of one day results in an allowable amount of \$1,118.00.
 - 28 Texas Administrative Code §134.401(c)(4)(A), states “When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274).”
 - A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at \$35,105.00.
 - Review of the medical documentation provided finds that although the requestor billed items under revenue code 278, no invoices were found to support the cost of the implantables billed. For that reason, no additional reimbursement can be recommended.

The division concludes that the total allowable for this admission is \$1,118.00. The respondent issued payment in the amount of \$2,100.78. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result no additional reimbursement can be recommended.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	3/27/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.